STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN4202SNF	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

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Z 000	Initial Comments This Statement of Deficiencies was generated as a result of a State Licensure survey and complaint investigation conducted in your facility on July 6, 2009 through July 10, 2009, in accordance with Nevada Administrative Code, Chapter 449, Facilities for Skilled Nursing. The census was 70 residents. The sample size was extended to 20 sampled residents which included 2 closed records. Complaint #NV00022281 was unsubstantiated. Complaint #NV00022459 was substantiated with deficiencies cited at Z 302, Z 303, and Z 315. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.	Z 000		
Z111 SS=G	NAC 449.74439 Comprehensive Plan of Care 2. A comprehensive plan of care must include: a) Measurable objectives and timetables to meet the physical, mental and psychosocial needs of the patient that are identified in the comprehensive assessment required by NAC 449.74433; b) A description of the services that will be provided to the patient to attain or maintain his highest practicable physical, mental and psychosocial well-being; and c) A description of the services that would otherwise be provided to the patient, but will not be provided because of the patient's refusal to accept those services. This Regulation is not met as evidenced by:	Z111		

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Z111	Continued From page 1 Based on observation, interview, and record review, the facility failed to develop care plans based on resident assessment for 2 of 20 residents regarding swallowing problems (Residents #1, #2), for 1 of 20 residents regarding positioning (Resident #2), and for 1 of 20 residents regarding dental care, chewing problems and weight loss (Resident #4). Findings include: Resident #4 Resident #4 was originally admitted on 10/28/08, with a re-admission on 5/4/09. The resident's diagnoses included dementia, debility, cellulitis of the lower left leg, anemia, vitamin and vitamin B12 deficiency. On 7/6/09, during the course of observing Resident #4 eating a mechanical soft diet, the resident took a long time in chewing the food. Upon closer observation of the resident it was noted that the resident was missing multiple teeth. On 7/6/09, in an interview with the Graduate Nurse (Employee #12), the nurse confirmed Resident #4 had chewing problems, missing teeth and other dental needs which needed attention. The nurse indicated that the family had identified that the resident was having difficulty eating and had requested a diet change, which had been changed to mechanical soft diet. The nurse also indicated that she thought that the family was looking into getting the resident a dental appointment. Review of the resident's Minimum Data Set (MDS) assessments, starting with the initial	Z111		

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Z111	Continued From page 2 admission assessment with reference date of 11/07/08, followed by a significant change assessment with reference date of 5/11/09 and a quarterly assessment with a reference date of 6/2/1/09, revealed on all occasions that Section L. Oral/Dental Status did not indicate the resident's appropriate status of natural and lost/missing teeth. The indicator in this section, on all occasions, was coded with "f" which indicated the resident needed daily cleaning of teeth/denture or daily mouth care-by resident or staff. The MDS indicated the resident was severely cognitively impaired in decision making. On 7/6/09, review of Resident #4's Observation Details records from 11/11/08 through 5/19/09, documented by both the facility's dietary supervisor and dietician the resident had only been consuming 25% of her meals and had chewing problems. A Progress Note documented on 5/19/09, by the dietician that the resident had lost 10 pounds in a 5 to 6 month period. Review of Resident #4's weight record revealed an admission weight on 10/28/08 of 133 pounds, by 12/26/08 the resident had lost seven pounds with a weight of 126 pounds. The resident continued to lose weight and on 5/7/09 was down to 115 pounds. Over a three month period the resident had a 5.3% weight loss, with an overall 14% weight loss over six months. Review of an entry in Resident #4's Progress Notes, dated the morning of 5/06/09 by a licensed nurse, indicated that a nursing assistant notified the nurse the resident was bleeding from the mouth. The note indicated the licensed nurse examined the resident's mouth and identified the resident had rotten broken teeth.	Z111		

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Z111	Continued From page 3 A Care Conference note dated 6/11/09 indicated that the family stated the resident needed to be evaluated for removal of teeth and expressed concern the resident may have needed pain medication for multiple reasons. Among family members and other facility staff, the care conference held on 6/11/09 was attended by the facility's MDS coordinator, Social Worker, Director of Nursing, and Food Services Director. On 7/9/09, in an interview with the facility's Dietary Supervisor (Employee #5) to discuss Resident #4's dental, chewing and weight loss concerns, the supervisor indicated she was not aware the resident's weight loss should have been care planned. The supervisor indicated she was also not aware of the association or possible relationship of the dental concerns in contributing to the resident's chewing difficulties and weight loss, or the need to have these concerns addressed to prevent future weight loss. Resident #4's medical record and care plan failed to reveal a care plan(s) to address the dental issues, chewing problems, pain associated with dental concerns, the progressive weight loss or the need for a dental appointment. Cross reference Tag Z 300. Resident #1 Resident #1 was admitted to the facility on 5/11/07 with diagnoses including dementia, hypertension and failure to thrive. The annual Minimum Data Set (MDS) completed on 4/26/09 identified the resident as having a	Z111		

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Z111	Continued From page 4 swallowing problem. On two occasions, the resident was observed in her wheelchair at the dining table. She was unable to sit upright and leaned severely to the side. Her husband and caregiver were present on both occasions. They were observed to "pull" her upright and place a pillow beside to keep her in position. When the husband was interviewed, he stated that he was afraid that Resident #1 would choke while being fed if he didn't change her position. There was no evidence that a care plan was developed for the problem of swallowing. Resident #2 Resident #2 had been in the facility since 9/6/07. Diagnoses included dementia, osteoarthritis, and hypertension. The quarterly MDS completed on 11/20/08, identified Resident #2 as having a swallowing problem. There was no evidence of a care plan for the swallowing problem. During the lunch time meal on 7/6/09, it was observed that Resident #2 was transferred from her wheelchair to a regular dining chair in the 200 Hall dining room. The resident cried out loudly during the transfer process . During the remainder of the meal, she continued to cry and was noted to be leaning to one side. There was no evidence of a care plan addressing the positioning problem. Resident #14 An interview with the social worker (Employee #7) on 7/9/09, confirmed she was involved in the care	Z111		

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Z111	Continued From page 5 conferences of the residents. She confirmed that the current care plans of the residents were not reviewed or updated during these care conferences. The social worker confirmed that an unscheduled care conference was held on 7/1/09. This care conference was conducted to address Resident #14 hiding food and alcohol in his room, medication contraindications as well as the safety of other residents. Staff present were the Director of Nursing, the Administrator, Activities Director, Dietary manager and the Social Worker as well as Resident #14, his public guardian and the local Ombudsman. Pain management, medication compliance and alcohol use were discussed and agreed upon to ensure Resident #14 would have the highest practicable mental and psychosocial well-being. There was no change to the care plan. The social worker acknowledged that even with the care conference intervention, Resident #14's care plan was not reviewed or revised to reflect the agreed upon interventions. Severity 3 Scope 1	Z111		
Z300 SS=G	NAC 449.74491 Prohibited practices 1. A facility for skilled nursing shall adopt and carry out written policies and procedures that prohibit: a) The mistreatment and neglect of the patients in the facility; b) The verbal, sexual, physical and mental abuse of the patients in the facility; c) Corporal punishment and involuntary seclusion; and d) The misappropriation of the property of the	Z300		

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Z300	Continued From page 6 patients in the facility. This Regulation is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to prevent the mistreatment and neglect of 2 of 20 residents (Residents #11, #4). Findings include: Resident #11 Resident #11 was admitted to the facility on 11/17/06. Her diagnoses included dementia, anxiety, and chronic pain. She was basically non verbal and wheelchair bound. On 7/6/09 at approximately 11:35 AM at the main nurse's station, loud sobbing was heard. Looking about the immediate surroundings, Resident #11 was observed seated in her wheelchair with no staff noted approaching her. Tears were streaming down her face. When asked if she needed help the resident nodded her head, "Yes." When asked if in pain, the resident again nodded her head, "Yes." A female staff person was summoned from sitting at the desk, to help the resident. The staff member immediately approached Resident #11. As the staff person talked to the resident, Licensed Practical Nurse (LPN -Employee #11), who was also seated at the desk, called out to the staff person, "She is all right, you know she has that chronic thing and you can't understand her anyway. I was just with her a few minutes ago." The LPN then stated, "She cries all the time." The first staff person pushed the resident down the hall and returned several minutes later and stated , "I redirected her. I asked her if she wanted to watch Westerns." After immediately searching for	Z300		

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Z300	Continued From page 7 Resident #11, the resident was observed in the nearly empty dining room of 200 Hall. The resident was seated at the dining table facing a window with closed blinds. No one else was observed at the table. A television, with a Western playing, was located in the adjoining living room. It could not be seen or heard by Resident #11. Review of the record disclosed Resident #11 received Vicodin twice a day for chronic pain. A care plan for for complaints of chronic pain contained the following approaches: - evaluate the effectiveness of pain management - position for comfort as needed - elevate feet if necessary - monitor and record any complaints of pain. Also present were care plans for anxiety and periodic crying. The care plan for anxiety had approaches to monitor for drug effectiveness, monitor resident's functional status each shift, and to quantitatively and objectively document the resident's behavior/mood. The approaches for the episodes of crying included to change her brief after dinner for relief and comfort, test the temperature of the shower water and to give her a toy to hold, take for a walk outside, provide with a communication board for her aphasia, take extra time to allow her to express herself and to offer water for thirst. There was no evidence any evaluation of the resident's status was undertaken or that any of the care plan approaches were utilized. Resident #4	Z300		

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Z300	Continued From page 8 Resident #4 was originally admitted on 10/28/08, with a re-admission on 5/4/09. The resident's diagnoses included dementia, debility, cellulitis of the lower left leg, anemia, vitamin and vitamin B12 deficiency. On 7/6/09, during the course of observing Resident #4 eating a mechanical soft diet, the resident took a long time in chewing the food. Upon closer observation of the resident it was noted that the resident was missing multiple teeth. On 7/6/09, in an interview with the Graduate Nurse (Employee #12), the nurse confirmed Resident #4 had chewing problems, missing teeth and other dental needs which needed attention. The nurse indicated that the family had identified that the resident was having difficulty eating and had requested a diet change, which had been changed to mechanical soft diet. The nurse also indicated that she thought that the family was looking into getting the resident a dental appointment. Review of the resident's Minimum Data Set (MDS) assessments, starting with the initial admission assessment with reference date of 11/07/08, followed by a significant change assessment with reference date of 5/11/09 and a quarterly assessment with a reference date of 6/2/1/09, revealed on all occasions that Section L. Oral/Dental Status did not indicate the resident's appropriate status of natural and lost/missing teeth. The indicator in this section, on all occasions, was coded with "f" which indicated the resident needed daily cleaning of teeth/denture or daily mouth care-by resident or staff. The MDS indicated the resident was severely cognitively	Z300		

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Z300	Continued From page 9 impaired in decision making. On 7/6/09, review of Resident #4's Observation Details records from 11/11/08 through 5/19/09, documented by both the facility's dietary supervisor and dietician the resident had only been consuming 25% of her meals and had chewing problems. A Progress Note documented on 5/19/09, by the dietician that the resident had lost 10 pounds in a 5 to 6 month period. Review of Resident #4's weight record revealed an admission weight on 10/28/08 of 133 pounds, by 12/26/08 the resident had lost seven pounds with a weight of 126 pounds. The resident continued to lose weight and on 5/7/09 was down to 115 pounds. Over a three month period the resident had a 5.3% weight loss, with an overall 14% weight loss over six months. Review of an entry in Resident #4's Progress Notes, dated the morning of 5/06/09 by a licensed nurse, indicated that a nursing assistant notified the nurse the resident was bleeding from the mouth. The note indicated the licensed nurse examined the resident's mouth and identified the resident had rotten broken teeth. A Care Conference note dated 6/11/09 indicated that the family stated the resident needed to be evaluated for removal of teeth and expressed concern the resident may have needed pain medication for multiple reasons. Among family members and other facility staff, the care conference held on 6/11/09 was attended by the facility's MDS coordinator, Social Worker, Director of Nursing, and Food Services Director. On 7/9/09, in an interview with the facility's Dietary Supervisor (Employee #5) to discuss	Z300		

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Z300	Continued From page 10 Resident #4's dental, chewing and weight loss concerns, the supervisor indicated she was not aware the resident's weight loss should have been care planned. The supervisor indicated she was also not aware of the association or possible relationship of the dental concerns in contributing to the resident's chewing difficulties and weight loss, or the need to have these concerns addressed to prevent future weight loss. Resident #4's medical record failed to reveal a care plan(s) to address the dental issues, chewing problems, pain associated with dental concerns, the progressive weight loss or the need for a dental appointment. Severity 3 Scope 1	Z300		
Z302 SS=H	NAC 449.74491 Prohibited practices 3. The results of any investigation must be reported: a) To the administrator of the facility or his designated representative and to the bureau within 5 working days after the alleged violation is reported. b) In the manner prescribed in NRS 200.5093 and 432B.220 and chapter 433 of NRS. The administrator of the facility shall take appropriate action to correct any violation. This Regulation is not met as evidenced by: Based on clinical record review, personnel record review, interview, and document review, the facility failed to report and thoroughly investigate and prevent further potential abuse while investigation was in progress of allegations involving mistreatment, neglect, abuse, and injury of unknown origin or events with significant/suspicious injury for 5 of 20 residents	Z302		

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Z302	Continued From page 11 (Residents #1, #14, #16, #18, #19). Findings include: Resident #16 Resident #16 was originally admitted on 3/09/07 with a re-admit on 5/11/09. Diagnoses included chronic airway obstruction, dementia, hypertension and congestive heart failure, and had difficulty walking. Progress notes dated 6/23/09 at 11:23 AM, documented the resident "stood up from wheel chair and fell on right side. Noted laceration to right eye. Resident will not response to any questions." It was further documented that the physician was notified and non emergent transport was called. Documentation at 11:40 AM, reported Resident #16 had symptoms of a seizure and was sent to the hospital at 11:55 AM. There was no additional charting in the progress notes. The resident's face sheet revealed the resident was discharged from the facility at 11:40 AM on 6/23/09. On 7/09/09 at 10:15 AM, an interview with Employee #1 and #2 revealed Resident #16 had expired in the hospital. When asked why the incident was noted on the facility's event log but was not reported to the appropriate agencies, they both responded that they were unaware that witnessed events had to be reported to any of the agencies. Resident #1 Resident #1 was admitted to the facility on	Z302		

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Z302	Continued From page 12 5/11/07 with diagnoses that included dementia, hypertension and failure to thrive. A complaint was received which alleged the resident had been sexually assaulted during the evening of 5/27/09, by a male resident of the facility. Review of the facility's event log disclosed that the allegation was entered on the log, but that the event had never been reported to any agency as mandated. On 7/7/09 at 2:20 PM, the administrator revealed she completed an internal investigation after the allegation was reported to her on 5/28/09. The investigation consisted of interviewing staff as well as the alleged victim's roommate who made the allegation. The administrator had Resident #1 examined physically, by the Director of Nursing. The resident was not interviewable due to her advanced state of dementia. The administrator's deduction was there was no validity to the allegation and therefore treated the event as an incident. The allegation of a sexual assault was not reported to the local law enforcement until the Division for Aging Services (Ombudsman) became involved. The police, after their investigation, closed the case because they did not feel that any crime had been committed. The administrator felt, based on her own internal investigation and the police investigation, that the allegation had not occurred, and did not believe this was a reportable incident since it was unsubstantiated. The facility's policy on "Abuse Prohibition," revised 2/05, stated that if the incident involved alleged abuse or neglect, "the Administrator shall provide the Bureau of Licensure and Certification	Z302		

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Z302	Continued From page 13 (BLC) and the Division of Aging Services Ombudsman Office (DAS) with initial notice of the alleged abuse or neglect. The notification will occur within 24 hours after the incident becomes known." The policy also defined abuse as verbal, sexual, physical, including corporal punishment, neglect, misapporation of property and involuntary seclusion. The terms of the investigation defined in the same policy included interviews of all involved parties or potential witnesses by two interviewees if possible. Signed statements were to be obtained from these parties. Documentation in the resident's medical report should include the nature and extent of any injuries incurred, whether the resident was sent to the hospital and if the physician was notified. After the internal investigation was completed, the findings should be reported to BLC and DAS within five working days. The administrator was unable to provide documentation of interviews from involved parties, the police report or a summary of the administrator's internal investigation. Resident #18 On 7/9/09, review of the facility's Resident Accident & Incident Reports log revealed an entry dated 6/29/09, for Resident #18, which indicated the resident had fallen and was sent to the hospital for an evaluation. The log further indicated that the Bureau of Health Care Quality and Compliance (state agency previously known as Bureau of Licensure and Certification (BLC)) was not notified. Resident #18's medical record revealed an Event	Z302		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z302	Continued From page 14 Report entry on 6/29/09 at 10:53 AM. The description identified the resident was on the ground when the nurse came and staff stated the resident hit her head and hip. The progress note dated 6/29/09 at 11:00 AM, indicated neuro checks were done. The resident had a grimacing expression on her face while walking and transferring back to bed and that the resident was transported by ambulance to the hospital at 10:53 AM. The note also indicated the resident's daughter and son were informed of the incident. A progress note at 3:24 PM, indicated the resident returned from the hospital and had a contusion (bruise) on the left shoulder. Further review of Resident #18's medical record revealed a history of falls. Review of Resident #18's care plan, with a problem start date of 3/18/09, documented the resident was at increased risk for falls due to senile psychosis, unsteady gait, cognitive impairment, psychotropic drug use and history of falls. The care plan goals and approaches were dated 6/19/09, and had not been updated following the 6/29/09 event. There was an approach list which indicated there was to be a Tab alarm on the bed. The goals and approaches failed to address medication assessment, physical therapy evaluation or other preventative measures. On 7/9/09, in an interview with the administrator (Employee #1), the administrator indicated that she was not sure why the 6/29/09 event which required Resident #18 to be evaluated at the emergency room, had not been reported to the state agency. In a later interview with both the administrator (Employee #1) and the Director of Nursing (DON)	Z302		

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	NVN4202SNF	A. BUILDING _____ B. WING _____	07/10/2009

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Z302	Continued From page 15 (Employee #2) on 7/9/09, the administrator and DON indicated that they were not aware the event was required to be reported. Resident #19 Review of the facility's Resident Accident & Incident Reports log on 7/9/09 revealed an entry dated 6/30/09 with the following documentation: "head laceration and swelling to right hip; transported to hospital." The log indicated the Bureau of Health Care Quality and Compliance (state agency) was not notified of the event/injury. Review of Resident #19's medical record revealed an Event report entry on 6/30/09 at 2:20 PM, and included the following description: "At 2:15 PM, was called to resident room. Resident was lying on floor on her back. Large amount of red blood pooling under her head. Pressure applied to back of head. Moves arms and legs without distress. Has large loose fluid sac on right hip. Aides state this is new..." Progress notes dated 6/30/09 indicated that the resident's physician had called for an order to transfer her to the Emergency Room, and that she had returned at 4:48 PM in stable condition. The care plan for Resident #19 revealed the resident had a history of falls and was at increased risk for falls due to cognitive deficit, unsteady gait, and generalized weakness. The goal indicated on the care plan was the resident "will not have any injury in relation to falls by next revision date." The care plan indicated a goal target date of 6/9/09, which had not been updated following the 6/20/09 event.	Z302		

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Z302	Continued From page 16 In an interview on 7/9/09 with the administrator, Employee #1, and the Director of Nursing (DON), Employee #2, the administrator and DON indicated they were unaware that significant events requiring residents to be sent out of the facility for medical attention were to be reported to the state agency. Resident #19 Review of the facility's Resident Accident & Incident Reports log on 7/9/09 revealed an entry dated 6/30/09 with the following documentation: "head laceration and swelling to right hip; transported to hospital." The log indicated the Bureau of Health Care Quality and Compliance (state agency) was not notified of the event/injury. Review of Resident #19's medical record revealed an Event report entry on 6/30/09 at 2:20 PM, and included the following description: "At 2:15 PM, was called to resident room. Resident was lying on floor on her back. Large amount of red blood pooling under her head. Pressure applied to back of head. Moves arms and legs without distress. Has large loose fluid sac on right hip. Aides state this is new..." Progress notes dated 6/30/09 indicated that the resident's physician had called for an order to transfer her to the Emergency Room, and that she had returned at 4:48 PM in stable condition. The care plan for Resident #19 revealed the resident had a history of falls and was at increased risk for falls due to cognitive deficit, unsteady gait, and generalized weakness. The goal indicated on the care plan was the resident "will not have any injury in relation to falls by next	Z302		

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Z302	Continued From page 17 revision date." The care plan indicated a goal target date of 6/9/09, which had not been updated following the 6/20/09 event. In an interview on 7/9/09 with the administrator, Employee #1, and the Director of Nursing (DON), Employee #2, the administrator and DON indicated they were unaware that significant events requiring residents to be sent out of the facility for medical attention were to be reported to the state agency. Severity 3 Scope 2	Z302		
Z303 SS=H	NAC 449.74491 Prohibited Practices 4. A facility for skilled nursing: a) Shall not employ a person if: (1) He has been convicted of abusing, neglecting or mistreating a patient; or (2) A finding that he has abused, neglected, mistreated or misappropriated the property of a patient has been entered in the state nurse aide registry maintained by the state board of nursing. b) Shall report to the state board of nursing the bureau or another appropriate occupational licensing board any judicial action taken against an employee or former employee of the facility which would indicate that the employee is unfit to be employed as a member of the staff of a facility for skilled nursing. This Regulation is not met as evidenced by: Based on clinical record review, personnel record review, interview, and document review, the facility failed to follow their Abuse and Neglect policy and protect, investigate, identify and report suspected abuse and neglect events, or events with significant/suspicious injury for 5 of 20 residents (Residents #1, #14, #16, #18, #19).	Z303		

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Z303	Continued From page 18 The facility failed to perform background screening timely for 6 of 11 personnel files (Personnel records #3, #4, #6, #7, #8, #10). Findings include: Resident #16 Resident #16 was originally admitted on 3/09/07 with a re-admit on 5/11/09. Diagnoses included chronic airway obstruction, dementia, hypertension and congestive heart failure, and had difficulty walking. Progress notes dated 6/23/09 at 11:23 AM, documented the resident "stood up from wheel chair and fell on right side. Noted laceration to right eye. Resident will not response to any questions." It was further documented that the physician was notified and non emergent transport was called. Documentation at 11:40 AM, reported Resident #16 had symptoms of a seizure and was sent to the hospital at 11:55 AM. There was no additional charting in the progress notes. The resident's face sheet revealed the resident was discharged from the facility at 11:40 AM on 6/23/09. On 7/09/09 at 10:15 AM, an interview with Employee #1 and #2 revealed Resident #16 had expired in the hospital. When asked why the incident was noted on the facility's event log but was not reported to the appropriate agencies, they both responded that they were unaware that witnessed events had to be reported to any of the agencies. Resident #1	Z303		

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Z303	Continued From page 19 Resident #1 was admitted to the facility on 5/11/07 with diagnoses that included dementia, hypertension and failure to thrive. A complaint was received which alleged the resident had been sexually assaulted during the evening of 5/27/09, by a male resident of the facility. Review of the facility's event log disclosed that the allegation was entered on the log, but that the event had never been reported to any agency as mandated. On 7/7/09 at 2:20 PM, the administrator revealed she completed an internal investigation after the allegation was reported to her on 5/28/09. The investigation consisted of interviewing staff as well as the alleged victim's roommate who made the allegation. The administrator had Resident #1 examined physically, by the Director of Nursing. The resident was not interviewable due to her advanced state of dementia. The administrator's deduction was there was no validity to the allegation and therefore treated the event as an incident. The allegation of a sexual assault was not reported to the local law enforcement until the Division for Aging Services (Ombudsman) became involved. The police, after their investigation, closed the case because they did not feel that any crime had been committed. The administrator felt, based on her own internal investigation and the police investigation, that the allegation had not occurred, and did not believe this was a reportable incident since it was unsubstantiated. The facility's policy on "Abuse Prohibition," revised 2/05, stated that if the incident involved	Z303		

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Z303	Continued From page 20 alleged abuse or neglect, "the Administrator shall provide the Bureau of Licensure and Certification (BLC) and the Division of Aging Services Ombudsman Office (DAS) with initial notice of the alleged abuse or neglect. The notification will occur within 24 hours after the incident becomes known." The policy also defined abuse as verbal, sexual, physical, including corporal punishment, neglect, misapporation of property and involuntary seclusion. The terms of the investigation defined in the same policy included interviews of all involved parties or potential witnesses by two interviewees if possible. Signed statements were to be obtained from these parties. Documentation in the resident's medical report should include the nature and extent of any injuries incurred, whether the resident was sent to the hospital and if the physician was notified. After the internal investigation was completed, the findings should be reported to BLC and DAS within five working days. The administrator was unable to provide documentation of interviews from involved parties, the police report or a summary of the administrator's internal investigation. Resident #14 On 5/25/09 at 10:00 AM, a licensed practical nurse (LPN), Employee #14 noted in the record that Resident #14 was kicked by another resident. On 7/9/09, Employee #14 revealed although she was aware a resident-to-resident event needed to be reported to the administrator, she did not reported this event. Employee #14 could offer no explanation why it was not reported. The administrator revealed she was present in the facility the day of the	Z303		

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Z303	Continued From page 21	Z303		

resident-to-resident event. The administrator denied any knowledge of the event, confirming no investigation was conducted.

Document review revealed the facility's policy contained the seven components of screening, training, prevention, identification, investigation, protection and reporting/response.

The facility's policy and practice to ensure residents were protected was to submit fingerprints of new employees within 10 days after their hire date, and to request reference checks.

Review of 11 personnel records with the Human Resources Director revealed:

Personnel record #3 was hired on 7/31/06, but there was no reference checks. Her fingerprints were not obtained until 8/24/06.

Personnel record #4 was hired on 2/1/09. Her fingerprints were not obtained until 3/20/09.

Personnel record #6 was hired on 7/17/07. Her fingerprints were not obtained until 1/30/08.

Personnel record #7 was hired on 9/12/06. There was no record of reference checks or professional references in her personnel file.

Personnel record #8 was hired on 5/21/08. Her fingerprints were not obtained until 7/10/08.

Personnel record #10 was hired in 6/4/08. There was no evidence of reference checks in his personnel file.

On 7/9/09, the Human Resources Director

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Z303	Continued From page 22 revealed, individual managers were informed they needed to obtain the fingerprints for the background checks. The facility was unable to provide evidence that employees recognized alleged abuse or neglect to report, or were able to return a demonstration of their comprehension of the training. In separate interviews with the activity staff, Employee #4 and Employee #15 on 7/7/09, both acknowledged they had no abuse and neglect training in over three years, although their education records revealed they had this training on a yearly basis. Interview with the administrator and the Director of Nursing (DON) on 7/7/09, revealed a failure to report events requiring a resident to be transferred to a hospital or other facility for further evaluation after a fall or event. The administrator and the DON acknowledged they were not aware an event with significant injury was defined as one that required the resident to be sent out of the facility for medical attention. The facility policy Section F: 6) described the facility was to notify the state agencies of "any injury of unknown source, which has or is likely to have a significant effect on the health, safety or welfare of a resident. Injuries requiring the services of a physician, hospital, police or fire department on an emergency basis shall be reported to the Bureau" (state agency - Bureau of Health Care Quality and Compliance). A review of the facility policy regarding protection of residents indicated that a staff member who was alleged to have a staff-to-resident event was to be suspended immediately.	Z303		

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Z303	Continued From page 23 On 7/7/09, the administrator and the social worker revealed they had become aware an allegation was received concerning a staff-to-resident physical altercation. The staff member involved was not scheduled to work for several days. The administrator and the social worker were not planning to suspend during the investigation. The administrator and social worker thought they could complete the investigation before the social worker returned to work. The administrator and social worker acknowledged by not suspending, the staff member could be called into work and place residents at risk for potential harm. The administrator and social worker agreed the policy was specific, that employees would be suspended immediately. There were no qualifiers or exceptions in the policy. Resident #18 On 7/9/09, review of the facility's Resident Accident & Incident Reports log revealed an entry dated 6/29/09, for Resident #18, which indicated the resident had fallen and was sent to the hospital for an evaluation. The log further indicated that the Bureau of Health Care Quality and Compliance (state agency previously known as Bureau of Licensure and Certification (BLC)) was not notified. Resident #18's medical record revealed an Event Report entry on 6/29/09 at 10:53 AM. The description identified the resident was on the ground when the nurse came and staff stated the resident hit her head and hip. The progress note dated 6/29/09 at 11:00 AM,	Z303		

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Z303	Continued From page 24 indicated neuro checks were done. The resident had a grimacing expression on her face while walking and transferring back to bed and that the resident was transported by ambulance to the hospital at 10:53 AM. The note also indicated the resident's daughter and son were informed of the incident. A progress note at 3:24 PM, indicated the resident returned from the hospital and had a contusion (bruise) on the left shoulder. Further review of Resident #18's medical record revealed a history of falls. Review of Resident #18's care plan, with a problem start date of 3/18/09, documented the resident was at increased risk for falls due to senile psychosis, unsteady gait, cognitive impairment, psychotropic drug use and history of falls. The care plan goals and approaches were dated 6/19/09, and had not been updated following the 6/29/09 event. There was an approach list which indicated there was to be a Tab alarm on the bed. The goals and approaches failed to address medication assessment, physical therapy evaluation or other preventative measures. On 7/9/09, in an interview with the administrator (Employee #1), the administrator indicated that she was not sure why the 6/29/09 event which required Resident #18 to be evaluated at the emergency room, had not been reported to the state agency. In a later interview with both the administrator (Employee #1) and the Director of Nursing (DON) (Employee #2) on 7/9/09, the administrator and DON indicated that they were not aware the event was required to be reported. Resident #19	Z303		

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Z303	Continued From page 25 Review of the facility's Resident Accident & Incident Reports log on 7/9/09 revealed an entry dated 6/30/09 with the following documentation: "head laceration and swelling to right hip; transported to hospital." The log indicated the Bureau of Health Care Quality and Compliance (state agency) was not notified of the event/injury. Review of Resident #19's medical record revealed an Event report entry on 6/30/09 at 2:20 PM, and included the following description: "At 2:15 PM, was called to resident room. Resident was lying on floor on her back. Large amount of red blood pooling under her head. Pressure applied to back of head. Moves arms and legs without distress. Has large loose fluid sac on right hip. Aides state this is new..." Progress notes dated 6/30/09 indicated that the resident's physician had called for an order to transfer her to the Emergency Room, and that she had returned at 4:48 PM in stable condition. The care plan for Resident #19 revealed the resident had a history of falls and was at increased risk for falls due to cognitive deficit, unsteady gait, and generalized weakness. The goal indicated on the care plan was the resident "will not have any injury in relation to falls by next revision date." The care plan indicated a goal target date of 6/9/09, which had not been updated following the 6/20/09 event. In an interview on 7/9/09 with the administrator, Employee #1, and the Director of Nursing (DON), Employee #2, the administrator and DON indicated they were unaware that significant events requiring residents to be sent out of the facility for medical attention were to be reported to the state agency.	Z303		

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Z303	Continued From page 26 Severity 3 Scope 2	Z303		
Z315 SS=E	NAC449.74495 Development of Program of Activities 1. A facility for skilled nursing shall provide for each patient in the facility a program of activities that is developed in accordance with the comprehensive assessment of the patient conducted pursuant to NAC 449.74433. This Regulation is not met as evidenced by: Based on interview, observation, record review and document review, the facility failed to ensure the activities programs were designed to meet individual interests and needs for 5 of 20 residents (Residents #10, #1, #2, #11, #16) and observed residents on the special care unit. Findings include: Observation on 7/6/09, in the special care unit revealed a group of women performing line dancing. Although approximately seven to nine residents were positioned so they could see the line dancers, five residents were seated away from this activity in a separated area. These five residents could not see the line dancers. The line dancing activity was observed for 20 minutes. There was no interaction between the performers and the residents. Three certified nursing assistants (CNAs) present did not try to engage the residents in this activity until the last five minutes when a CNA started dancing with a resident who had just walked in. When the dancers left, there was no interaction with the residents, such as verbal acknowledgement or physical gestures such as waving good-bye. An interview with the line dance coordinator after	Z315		

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Z315	Continued From page 27 the dancing revealed that they came to the facility to practice their routines. Further review of the activity calendar in the special care unit revealed there were no times listed on the calendar or daily event board to assist residents with knowing what activities were planned and when they would occur. An interview with the Employee #4 on 7/7/09, revealed that although she had the title of Activity Director, she had just started the training in April and had just completed her first class assignment. Employee #4 acknowledged she was not aware that as Activity Director, she was responsible for the entire facility activities program, including those on the special care unit. Review of the resident council meeting minutes revealed concerns of the residents were forwarded to the various department managers, but responses were not timely to address the residents' concerns. Examples were: - that maintenance and housekeeping department was informed after the 1/6/09 meeting the shower rooms were too cold "cold as a frog", the water was not always warm enough and the 200 dining room was cold. - the showers were not cleaned often enough. The maintenance and housekeeping department reply was 3/2/09. - April resident council meeting on 4/28/09, continued to express that the rooms and dining rooms were not clean. There was also the continued complaint that room and water temps continued to be a problem. As of 7/7/09, housekeeping had not responded and maintenance's reply was dated 7/7/09. Resident #10	Z315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN4202SNF	A. BUILDING _____ B. WING _____	07/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF FALLON	550 NORTH SHERMAN ROAD FALLON, NV 89406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z315	Continued From page 28 Record review revealed Resident #10 was blind, and required a merry walker to assist with her ambulation, and prevent injury. The activity log revealed the resident did not participate in volleyball or kickball. The log also described that she like to read and write. There was no documentation on how the activities had been revised to accommodate her blindness. Review of the quarterly assessments for Residents #1, 2, 11, and 16, disclosed the summaries to be very brief and lacked documentation as to what activities the residents participated in, how their participation compared to the previous quarter, if the residents had expressed any particular interest in specific activities or how involved the residents were in the individual activities and how the activities person planned to increase the involvement of the residents in activities for the coming quarter. Severity 2 Scope 2	Z315		